DSHS Community Mental Health and Substance Abuse Services
Resiliency and Disease Management
Fidelity Manual – October 2007
II.F Adult Mental Health Programs – Rural Assertive Community Treatment (Rural ACT)

Overview of the DSHS Rural ACT Model

- The goal of Rural ACT is to help people stay out of the hospital and to develop a level of recovery, so that their mental illness is not the driving force in their lives. Assertive community treatment offers services to all counties within the provider's service area. ACT services are customized to individual needs, delivered by a team of practitioners.
- Rural Assertive Community Treatment offers the most extensive package of benefits or level of care delivered through Resiliency and Disease Management. The Rural ACT multidisciplinary staff works as a team and collaboratively delivers the majority of treatment, rehabilitation, and support services required by each individual to live in the community. A psychiatrist is a member of, not a consultant to, the team. The individual is a client of the team, not of an individual staff member. Individuals with the most severe mental illnesses are typically not served well by the traditional outpatient model that directs patients to various services that they then must navigate on their own. Rural ACT goes to the individual whenever and wherever needed. The individual is not required to adapt to or follow prescriptive rules of a treatment program – National Alliance on Mental Illness (NAMI).
- The integrated Rural ACT team maintains full responsibility for the individual's continuity of services, psychiatric services, counseling, housing support services, substance abuse treatment, employment support services, and rehabilitative services with minimal referrals to other providers of mental health community services. In addition to these services, the Rural ACT team is encouraged to have a paid peer provider who has successfully completed the program. The services provided by a Rural ACT team are all-inclusive while focusing on stabilization and reduction of hospitalizations. Rural ACT includes outreach and engagement activities to assist the individual in seeing recovery as an attainable goal. Rural ACT services are available 24 hours a day, 7 days per week. The Rural ACT team is responsible for crisis services, hospital admissions, and discharge planning. The majority of Rural ACT services are delivered one-on-one to the individual while the individual is in the community (at least 80% of direct services are provided out of the office). The Rural ACT team provides support and rehabilitation for the individual and the individual's natural support system. These supports include but are not limited to providing information about the individual's illness and treatment, information about what to do in case of crisis, guidance about how to approach and support the individual, and how to access services in the community.
- Persons in Rural ACT are provided medications and patient and family education, according to Texas Implementation of Medication Algorithms (TIMA), by psychiatrists with smaller caseloads who are attached to an integrated team. Each Rural ACT team member should serve few ACT individuals (less than eight) on their caseload particularly when they are also serving individuals in other service packages. All Rural ACT team members should communicate at least 3 times a week by either telecommunication or face-to-face to review the status of each individual, communicate the outcomes of recent services, and plan and prioritize services and activities.
- The principal diagnosis for receiving Rural ACT (SP 4) are Schizophrenia and Related Disorders, or Bipolar Disorder. The individual must also have had at least two hospitalizations within the last 180 days or 4 or more hospitalizations within the last 2 years.

Overview of the Rural ACT Fidelity Scale

The Rural ACT fidelity scale is an instrument that is intended to measure the extent and faithfulness of implementation of Service Package 4 for the purposes of quality improvement and accountability to DSHS and by extension to the Texas Legislature and the citizens of the state. It is expected that the scale and its supporting documentation be used as a training tool that expands upon didactic presentations and furthers practical understanding of an integrated rehabilitative case management model and its appropriate implementation. The scale thus serves as an implementation guide and ideally is used internally as a monitoring system on progress in implementation and culture change in the organization. Although total scores for the instrument can be obtained, individual item scores are more valuable in tracking implementation and guiding further system change and decision-making, as each item or element is considered essential.

Elements of the Rural ACT Fidelity Scale: The Primary Provider Services and Staff Training sections are organizational or team measures. The remaining sections are based either on the individual or if across all individuals receiving the service model the primary information source will be encounter data.

A. Primary Provider Services
B. Staff Training
C. Community Integration and Highly Individualized Services
D. Assertive Approach
E. Emphasis on Supported Employment and Housing Services
F. Criminal Justice
G. Co-Occurring Psychiatric and Substance Abuse Disorders (COPSD) Services
H. Family Support and Education

Items in the scale are the essential elements of Rural ACT agreed upon by a workgroup consisting of DSHS policy staff and representatives from community mental health centers. The group further divided some of the essential elements into sub-elements for the purpose of mapping levels of adherence to Rural ACT and making the fidelity rating system practical and useful.

How Items are Rated

The Rural ACT fidelity review instrument consists of 35 items which are to be rated individually on a Yes/No Scale with "1" denoting no or minimal implementation of the services and "5" reflecting a faithful implementation.

Rapid Review Process

A subgroup of the fidelity review elements will be reviewed as a part of the Rapid Review process. Some of the elements, designated by gray fill and (RR) on the Fidelity Instrument, are items to be reviewed as a part of the Rapid Review process. The Rapid Review process has been developed to serve as both a readiness measure and to ensure that critical structural elements remain in compliance on an ongoing basis. The Rapid Review Instrument is a self-assessment checklist designed to be administered by LMHA/MMCO quality management staff with assistance from provider staff. All internal and external providers of each service model should be assessed. Provider staff most familiar with the service should complete a checklist for each service model. The LMHA/MMCO staff will collect the provider checklist to compile the aggregate results. The Rapid Review rating scales will consist of “Yes” for current practice or “No” for not evident. The results will be used both internally and externally to monitor structural adherence to the service model. The Rapid Review process may involve different elements over time, allowing for a more complete picture of service. The rapid review elements will be evaluated until readiness is achieved. Both state and local authorities will use fidelity data to improve internal processes and compliance.

Sources of Information

Information used in rating elements is obtained from clinical record reviews, observations made through site visits, Human Resource records, policies and procedures, organizational charts, supervision notes, program descriptions, on-call logs, encounter data, and interviews with individuals, staff and/or other providers. Many elements are scored using multiple sources of data and information.

Information sources may include:

- Record review - a sample of records is selected randomly and each record is individually reviewed and an aggregate score obtained by simple average
- Interview - a sample of appropriate persons to interview is selected, responses are individually rated and an aggregate score obtained by simple average
- Combination of records and interviews - scores may be reported separately or averaged to get a final score
- Policies and procedures - requirements related to new employee orientation, requisite staff training, credentialing, recruitment, hiring
- Encounter data

- Organizational charts - scope of authority and lines of supervision
- Other documentation – human resource records, job descriptions, staff training records

When scoring records or interviewing individuals, family members, or staff, information is gathered that covers a specific time period as measured backwards in time from the review date. The sample should include individuals receiving assertive community services and the staff who provide those services within the last 3 months. Reviews not involving interviews or clinical records are scored as to their status at the time of the review. This allows for progress in implementation and corrections of systemic problems to be reflected in subsequent reviews in a reasonable time frame.

Rural ACT Fidelity Review Protocol

A. Primary Provider of Services

The multidisciplinary make-up of each team and the small individual-to-staff ratio allows the team to provide most services with minimal referrals to other mental health programs or providers. The Rural ACT team members share offices and their roles are interchangeable when providing services to ensure that services are not disrupted due to staff absence or turnover. This team may not be solely an ACT dedicated team. These members are allowed to serve other services packages as needed.

Element #1 – Small Caseload (Rapid Review)

Definition: The individual-to-staff ratio must take into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered. Staff may serve other service packages in addition to Rural ACT individuals. The caseload generally has less than eight individuals in Rural ACT services in addition to individuals served in other service packages. A lower rural caseload size is indexed to the severity of need and functioning level of the persons served or is provided a more rural area that requires a greater amount of travel time. The provider identifies who the team members are (i.e., roster) and include within the job description the percentage of time devoted to the Rural ACT services.
Rationale: The Rural ACT team works collaboratively to deliver the majority of treatment, rehabilitation and support services required by each individual to obtain a level of recovery that enables them to live in the community.
Sources of Information: Human resource records, staff training records, job description, interviews
Item Scoring: [Yes (5) or No (1)]

1.) The ACT individual to ACT staff/ratio exceeds 8:1.
2.) N/A
3.) N/A
4.) N/A
5.) The ACT individual to ACT staff/ratio is 8:1 or less.

Element #2 – Team Meeting (Rapid Review)

Definition: Communication among team members is for the purpose of creative planning, problem solving, sharing knowledge of resources and information, cross training, systematic consultation and support of the team members. Possible topics for discussion include, but are not limited to clinical highlights, challenging issues for individuals, crisis planning, and treatment changes. Communication may be accomplished via teleconference, televideo, email or a communication log in which important events or occurrences related to individuals are documented for the purpose of sharing the information with other team members.
Rationale: To measure the frequency and modality of the teams' communication, problem solving, training and consultation among its members.
Sources of Information: Team meeting notes, interviews, observation
Item Scoring: [Yes (5) or No (1)]

1.) There are not at least 3 (times per week) documented opportunities for communication and consultation among team members and documented intermittent briefings with the psychiatrist based on the individual's needs.
2.) N/A

3.) N/A
4.) N/A
5.) There are at least 3 (times per week) documented opportunities for communication and consultation among team members and documented intermittent briefings with the psychiatrist based on the individual's needs.

Element #3 – Degreed staff on the Treatment Team
Definition: At least 80% of the Rural ACT team consists of at least a Qualified Mental Health Professional – Community Services (QMHP-CS) who possess at least a bachelor's degree.
Rationale: The Multidisciplinary composition of the team ensures sufficient numbers of specialists who have training, expertise, and experience in each program area so that the team can provide treatment, rehabilitation and support services; education and consultation to families; substance abuse services and assessment and case-management services.
Information Sources: Human resources data, staff training records
Item Scoring: [Yes (5) or No (1)]
1.) Less than 80% of the Rural ACT team consists of at least a QMHP-CS
2.) N/A
3.) N/A
4.) N/A
5.) 80% or more of the Rural ACT team consists of at least a QMHP-CS.

Element #4 – Team Leader Qualifications
Definition: A Team Leader is a Licensed Practitioner of the Healing Arts (LPHA). A Qualified Mental Health Professional – Community Services (QMHP-CS) with three years experience working with persons with severe and persistent mental illness and formal documented clinical supervision by a Licensed Practitioner of the Healing Arts (LPHA) may be "grandfathered if they have held that position prior to 9-1-07. When the Team Leader position becomes vacant, then it must be filled with a LPHA.
Rationale: The Team Leader must have a clear understanding of the problems and symptoms associated with adults who have severe and persistent mental illnesses.
Information Sources: Human resources data, staff training records
Item Scoring: [Yes (5) or No (1)]
1.) The Team Leader is not an LPHA.
2.) N/A
3.) N/A
4.) N/A
5.) The Team Leader is an LPHA or QMHP-CS that meets the "grandfathered" criteria.

Element #5 – Team Leader Duties
Definition: Team Leaders duties include facilitating service activities of the Rural ACT team staff, monitoring individual services, assigning case loads, and ensuring that services are delivered according to treatment plans and service package guidelines for persons being served on their team. Team Leader duties also include facilitation of the process of identifying team goals and working with each team member to ensure the attainment of those goals.
Rationale: To ensure that the team leader's responsibilities are included in a job description and the performance of assigned job duties.
Information Sources: Encounter data, clinical records, team meeting minutes, job description, interviews
Item Scoring: [Yes (5) or No (1)]
1.) Team Leaders do not demonstrate performance of required leadership duties
2.) N/A
3.) N/A

4.) N/A
5.) Team Leaders demonstrate performance of required leadership duties.

Element #6 – Staff Coverage (Rapid Review)
Definition: Each Rural ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation, and support services as needed. Staff is regularly scheduled to provide the necessary services on an individual by individual basis in the evenings, on weekends and during holidays,
Rationale: Flexibility, accessibility, and timeliness of service delivery are reflected in the team's ability to provide needed support and rehabilitation to individuals and their natural support system on evenings, weekends and holidays as needed, based on the consumers' needs and on an individual-by-individual basis. The individual consumer may have immediate needs not considered "a crisis"; such services are those deemed necessary to prevent a crisis situation or to prevent hospitalization.
Information Sources: Encounter data, on call records, staffing schedules
Item Scoring: [Yes (5) or No (1)]
1.) There is not documented evidence that staff is available to provide service on evenings, holidays and weekends as needed.
2.) N/A
3.) N/A
4.) N/A
5.) There is documented evidence that staff is available to provide service on evenings, holidays and weekends as needed.

Element #7 – Registered Nurse on the Team (Rapid Review)
Definition: Registered Nurse as team member. Prior to delivering services, the registered nurse must receive training on episodes of acute symptomology and the nature of severe psychiatric illness. This team member may also provide services to individuals in other service packages.
Rationale: Registered Nurse to provide medication management, health assessment, guidance, and quality assurance to respond to the medical needs that accompany individuals who are vulnerable to the cyclical episodes of acute symptomatology and low cognitive functioning.
Information Sources: Human Resources records, staff training records, encounter data, job description
Item Scoring: [Yes (5) or No (1)]
1.) There is not a Registered Nurse on the team with required training.
2.) N/A
3.) N/A
4.) N/A
5.) There is a Registered Nurse on the team with required training.

Element #8 –Psychiatrist on the Team (Rapid Review)
Definition: A psychiatrist is available for consultation by Rural ACT team members at all times. This team member may provide services to individuals in other service packages.
Rationale: A psychiatrist is available for consultation by Rural ACT team members at all times to respond to the pharmacological management needs that accompanies individuals who are vulnerable to the cyclical episodes of acute symptomatology.
Information Sources: Human Resources records, team meeting notes, encounter data, job description
Item Scoring: [Yes (5) or No (1)]
1.) No regularly assigned psychiatrist.
2.) N/A
3.) N/A
4.) N/A
5.) A psychiatrist is available for consultation by Rural ACT team members at all times.

Element #9 - Supported Employment Specialist on the Team (Rapid Review)
Definition: The Rural ACT team includes at least one FTE who has received training and demonstrated competency in vocational rehabilitation and employment support. Supported employment services result in community employment in regular jobs, with non-disabled coworkers. The Supported Employment Specialist may provide other services in addition to assisting the individual with employment needs.
Rationale: Supported employment services require specialized knowledge of vocational rehabilitation and employment strategies.
Information Sources: Human Resources records, staff training records, job description
Item Scoring: [Yes (5) or No (1)]

1.) There is no staff with supported employment training and demonstrated competency.
2.) N/A
3.) N/A
4.) N/A
5.) There is at least one FTE team member with supported employment training and demonstrated competency.

Element #10 – Supported Housing Specialist on the Team (Rapid Review)
Definition: The Rural ACT Team includes at least one FTE that is trained and experienced in providing services to individuals with housing issues and that need linkage: with landlords, public housing and Section 8 resources. The Supported Housing Specialist may provide other services in addition to assisting the individual with housing needs.
Rationale: Supported employment services require specialized knowledge of housing issues and services.
Information Sources: Human Resources records, staff training records, job description
Item Scoring: [Yes (5) or No (1)]

1.) There is no staff with housing training and demonstrated competency.
2.) N/A
3.) N/A
4.) N/A
5.) There is at least one FTE team member with housing training and demonstrated competency.

B. Staff Training
ACT teams require adequate numbers of staff members with sufficient individual competence to carry out the array of services and to establish quality supportive relationships with individuals.

Element #11 – Critical Staff Training (Rapid Review)
Definition: Staff providing Rural ACT services are trained prior to delivering services and receive subsequent refresher training. Training must include competency measures in psychosocial rehabilitation, rehabilitation, Co-Occurring Psychiatric and Substance Abuse Disorders, the Patient and Family Education Program, assessment and treatment planning, uniform assessment, cultural competency, recovery model, stages of change, Utilization Management Guidelines, and Resiliency and Disease Management.
Rationale: To measure the training of Rural ACT team members. ACT teams require competence to carry out the array of services.
Information Sources: Human resources data, staff training records
Item Scoring: [Yes (5) or No (1)]

1.) Rural ACT team members did not receive initial training and a refresher (as applicable).
2.) N/A
3.) N/A
4.) N/A
5.) All Rural ACT team members receive initial training and a refresher (as applicable).

Element #12 – Staff Development and Supervision

Definition: The following staff development and supervision strategies are used to ensure that all staff achieve and maintain the competency needed to provide services. Implementation of this requirement is demonstrated by experienced supervisors holding regular supervision conferences with the Rural ACT team, staff with limited experience are paired with mentors, and the organization establishes a functioning system to increase levels of staff knowledge and competence. Each ACT team must develop a written policy for clinical supervision of all staff providing treatment, rehabilitation, and support services. Other creative strategies are also implemented to increase staff competency.

Rationale: To measure the training of Rural ACT staff, the expertise of supervisory staff, the mentoring of less experienced staff and the effectiveness of the providers' ongoing training initiatives.

Information Sources: Human resources data, staff training records, team meeting minutes, supervisory notes

Item Scoring: [Yes (5) or No (1)]

1.) There is no evidence of supervision, mentoring, and other staff development strategies.
2.) N/A
3.) N/A
4.) N/A
5.) There is evidence of supervision, mentoring, and other staff development strategies.

C. Community Integration and Highly Individualized Services

Treatment plans, developed with the individual, are based on individual strengths and needs, hopes and desires. The plans are modified as needed through an ongoing assessment and goal setting process. Rehabilitation occurs in-vivo within the community settings, such as: a person's home and neighborhood, local restaurants, parks and nearby stores. Coordination services assist individuals in gaining and coordinating access to necessary care and services appropriate to the needs of the individual. Services are delivered in-vivo with a limited amount of provider office-based services. The Rural ACT team uses rehabilitation opportunities and/or supportive interventions to teach the individual how to be their own case manager and will help further their independent functioning in the community. These services promote community integration, increase community tenure, and maintain the individual's quality of life. Service includes: activities and training to address the illness or symptom-related problems and behavior that affects an individual's functioning. Initially, Rural ACT team members deliver as much of the "help" as possible with minimal referrals and then gradually replace the "help" they offer with natural supports and community resources. The length of services is indeterminate and expected to be ongoing although the intensity, at any point in time, may vary.

Element #13 – Initial Provider Assessment and Treatment Plan

Definition: An initial provider assessment and treatment plan must be completed by a team member who is at least a QMHP; preferably the Team Leader or psychiatrist. Provider assessment and treatment planning should include participation by designated team members.

Rationale To assess mental status, psychiatric history and to provide an accurate diagnosis from those listed in the American Psychiatric Association's DSM IV and then to effectively plan with the individual and the individual's family the best treatment approach to eliminate or reduce symptomatology.

Item Scoring: [Yes (5) or No (1)]

1.) The individual's initial provider assessment and treatment plan were not completed by the Team Leader or psychiatrist or a team member who is at least a QMHP.
2.) N/A
3.) N/A
4.) N/A
5.) The individual's initial provider assessment and treatment plan were completed by the Team Leader or psychiatrist or a team member who is at least a QMHP.

Element #14 –Treatment Services Provided to Rural ACT Individuals
Definition: The treatment plan addresses the individual's mental health service needs as determined by their assessments, and specific needs identified by the individual. Individuals identified as needing Rural ACT services will be prioritized for psychiatric medications, individual and family education and psychosocial rehabilitative services which include COPSD treatment, coordination services, rehabilitation, and supported housing. Supported Employment will be available for a limited number of persons in need of and desiring to work. The provision of services is directly related to the individual's recovery oriented goals and objectives in the treatment plan.
Rationale: To measure the extent to which the team members assess and address the full range of individual needs as identified in the treatment plan.
Information Sources: Clinical records, treatment plans
Item Scoring: [Yes (5) or No (1)]

1.) The individual's full range of needs was not addressed in treatment plan.
2.) N/A
3.) N/A
4.) N/A
5.) The individual's full range of needs was addressed in treatment plan.

Element #15 – In-vivo Services (Rapid Review)
Definition: Rural ACT services are provided in the individual's natural-environment. These services are provided within the community settings, such as a person's home and neighborhood, local restaurants, parks and nearby stores. The Rural ACT team uses rehabilitation methods and/or supportive interventions to teach the individual how to be their own case manager. Exceptions to in-vivo service delivery include medication services and group. Service time will be used to determine percentage of in-vivo service delivery.
Rationale: To measure the percentage of overall Rural ACT services provided in-vivo.
Information Sources: Clinical records, encounter data
Item Scoring: [Yes (5) or No (1)]

1.) The individual received less than 80% of services in-vivo.
2.) N/A
3.) N/A
4.) N/A
5.) The individual received at least 80% of services in-vivo.

Element #16 – Recovery Orientation in Service Delivery
Definition: Recovery can be defined as the overarching message that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society. Recovery is a process by which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Evidence based practices have shown that persons with the most severe mental illnesses can lead productive satisfying lives and that having hope plays an integral role in an individual's recovery.
Rationale: To measure the degree to which care is focused on increasing the individual's ability to successfully cope with life's challenges, on facilitating recovery and building resilience, not just on managing symptoms.
Information Source: Clinical records, interviews
Item Scoring: [Yes (5) or No (1)]

1.) No evidence of recovery in treatment planning and service delivery for each individual.
2.) N/A
3.) N/A

4.) N/A
5.) There is evidence of recovery in treatment planning and service delivery for each individual.

Element #17 – Training Methods
Definition: Effective skill training methods are the specific techniques staff will employ with individuals during skill training sessions. Rehabilitation is provided through a combination of staff providing instructions; modeling and demonstration; role playing, usually to try out a particular skill in a simulated interaction; using positive and corrective feedback with the individual; and through homework assignments and repetition. Practical strategies include defining the skill to be taught and breaking it down into components; emphasis of training on behavioral rehearsal, not discussion or didactic teaching; level of training geared to participant's current ability to assimilate the information; minimize demands on cognitive capacity as needed (e.g., handouts, have individuals describe what they will do before role play/rehearsal); shape new behavior by reinforcing successive approximations; and prompt and reinforce behavior in natural environment.
Rationale: To measure the degree to which the following effective skill training methods are used:

- Instructions – Directions for how an action, behavior, method, or task is to be accomplished
- Modeling – A physical demonstration of a desired outcome
- Role-play or rehearsal – The attempt by an individual to place themselves in the position of another, or as themselves, and deal with unfamiliar circumstances, and through such an experience increase their understanding of, either the role they have adopted or the circumstances they face, or both.
- Positive feedback and shaping – Information given by staff to the individual that provides either an honest assessment of a job well-done, or a helpful assessment of how the job could have been done better.
- Repetition of role-plays or rehearsal – Repetition of an action

Information Sources: clinical records
Item Scoring: [Yes (5) or No (1)]
1.) Less than 3 different rehabilitation methods are described in at least 75% of the individual's progress notes.
2.) N/A
3.) N/A
4.) N/A
5.) At least 3 different rehabilitation methods are described in at least 75% of the individual's progress notes.

Element #18 – Rehabilitation Curriculum (Rapid Review)
Definition: Staff uses a rehabilitation-based training curriculum that provides a structured approach to systematically teach individuals specific behaviors and skills. Rehabilitation is provided through the use of methods defined in #17 above.
Rationale: The use of established curriculum increases the probability that staff will utilize proven training techniques and strategies.
Information Sources: Training curriculum present at service delivery sites and staff offices, training curriculum used for staff training.
Item Scoring: [Yes (5) or No (1)]
1.) Training curriculum is not in use or the curriculum used utilizes only discussion and/or didactic teaching.
2.) N/A
3.) N/A
4.) N/A
5.) Training curriculum utilizing proven techniques and strategies is in use.

Element #19 – Intensity of Services
Definition: Service intensity refers to the frequency of various service contacts with the individual. Service intensity reflects active engagement strategies to reach out to individuals, the provision of supports and life management training at a frequency sufficient for the individual's functional impairments, and the provision of medical services at a frequency that ensures adequate assessment of treatment response or side effects and encourages adherence to

effective medication regimens. High intensity service is provided as needed with **an average of** 10 hours per month across all individuals on the Rural ACT team. There is active engagement to reach out to individuals, to provide supports and rehabilitation on a frequent and intense level to assist the individual in symptom reduction and increased functioning.
Rationale: Service intensity is high and uses a combination of face-to-face and supplemental telephone contacts.
Information Sources: encounter data
Item Scoring: [Yes (5) or No (1)]

1.) The team does not provide **an average of** 10 hours a month across all individuals on the Rural ACT team.
2.) N/A
3.) N/A
4.) N/A
5.) The team provides **an average of** 10 hours a month across all individuals on the Rural ACT team.

D. Assertive Approach

Rural ACT team members are pro-active with individuals, assisting them to participate in and continue treatment, live independently, and focus on recovery.

Element #20 – Responsibility for Crisis Services

Definition: Team members are available by phone for after-hours/crisis services predominantly in consulting role. Individuals have 24-hour, 7 days per week access (at least by phone) to Rural ACT team members who have familiarity and a relationship with the individual. This requires a system by the LMHA/MMCO through which the Rural ACT team is notified of all crisis calls from a Rural ACT individual. In addition, the staff must provide crisis services at least during regular work hours. During all other hours, the team may arrange coverage through a reliable crisis-intervention hotline. In this case, the rural team communicates routinely with the crisis-intervention hotline.
Rationale: To measure the degree to which team members are available for consultation in crisis situations.
Information Sources: Clinical records, encounter data, interviews
Item Scoring: [Yes (5) or No (1)]

1.) For each individual in crisis, an ACT team member did not respond at least by telephone in a consulting role.
2.) N/A
3.) N/A
4.) N/A
5.) For each individual in crisis, an ACT team member responded at least by telephone in a consulting role.

Element #21 – Responsibility for hospital admission

Definition: Rural ACT team members coordinate or are involved in all hospital admissions decisions. This involvement should occur for both local and state hospitalizations. The LMHA should also keep community collaboration with EMS, the local police department, collaterals (i.e., family, community), and hospital/ER personnel regarding notifications of an individual's hospitalization. Follow-up with the individual while hospitalized is a combined effort of the local authority staff and Rural ACT team members. Communication regarding hospital admission may include face-to-face, telephone, or e-mail.
Rationale: To measure the degree of team involvement when individuals are in referral situations or being admitted and/or discharged from a hospital.
Information Sources: Clinical records
Item Scoring: [Yes (5) or No (1)]

1.) The Rural ACT team did not coordinate or have involvement in the individual's hospital admission(s).
2.) N/A
3.) N/A
4.) N/A
5.) The Rural ACT team did coordinate or have involvement in the individual's hospital admission(s).

Element #22 – Responsibility for hospital discharge planning
Definition: Activities designed to ensure uninterrupted services are provided to Rural ACT individuals by team members, especially during a transition between service types (e.g., referral situations, hospital admission and discharge). Follow-up with the individual while hospitalized is a combined effort of the local authority staff and Rural ACT team members.
Rationale: To measure the degree of team involvement when individuals are in referral situations or being admitted and/or discharged from a hospital.
Scoring minimum: Team members participate in hospital admission and discharge planning.
Information Sources: Clinical records, treatment plans
Item Scoring: [Yes (5) or No (1)]

1.) Team members did not participate in the individual's discharge planning.
2.) N/A
3.) N/A
4.) N/A
5.) Team members participated in the individual's discharge planning.

Element #23 – Frequency of Contact
Definition: The Rural Act team must have the capacity to provide multiple contacts each week with individuals. The team must also have the capacity to rapidly increase service intensity to an individual when his or her status requires it or an individual requests it. Some individuals will need several contacts a day at certain points in their treatment while others will only need to be seen once a week. Small groups may also be used for the purpose of preventing isolation and for COPSD services.
Rationale: Supports and independent life management training for the individual should be provided on a frequent and intensive level to assist individual in symptom reduction, increase functioning, and achieve recovery.
Information Sources: Encounter data will be used to measure this element.
Item Scoring: [Yes (5) or No (1)]

1.) The Rural ACT team did not provide an average of three contacts per week across all individuals.
2.) N/A
3.) N/A
4.) N/A
5.) The Rural ACT team provided an average of three contacts per week across all individuals.

F. Emphasis on Supported Employment/Housing Expectations
As symptoms lessen and concentration improves, and as the individual begins to express some interest or need for employment, supported employment services are provided. The Rural ACT team directly provides employment services by actively assisting the person served to find, obtain, and maintain employment opportunities in community-based sites that are consistent with their recovery goals, values and preferences. The team will also offer long-term supports that will assist individuals in keeping employment and/or finding another job as necessary. Services are for individuals that have significant functional impairments or increased symptoms but who have stabilized to the point where they are able to fully participate and benefit from intensive specialized vocational services. The team encourages all individuals to participate in community employment and provides many vocational rehabilitation services directly.

Integrated Supported Housing is defined as normal, ordinary living arrangements typical of what is available to the general population. Integration is achieved when individuals with serious mental illness choose ordinary, typical housing units that are located among units for individuals who do not have mental illness. Housing without supports or services is not Supported Housing.

Supported Employment and Supported Housing services are provided by team member(s) who have competency in housing/employment services.

Element #24 – Benefits Planning
Definition: Supported employment services include providing information about how employment might impact SSA benefits.
Rationale: Lack of understanding about the impact of employment on Social Security is a major factor affecting people's choices about work.
Information Source: Clinical records
Item Scoring: [Yes (5) or No (1)]

1.) There is no documentation reflecting discussion or understanding of SSA benefits and employment for an individual with an assessed need.
2.) N/A
3.) N/A
4.) N/A
5.) There is documentation reflecting discussion or understanding of SSA benefits and employment for an individual with an assessed need.

Element #25 - Zero Exclusion Criteria (Supported Employment)
Definition: There are no eligibility exclusions for individuals with a history of substance abuse, violent behavior, or impaired intellectual functioning.
Rationale: This service is intended for people with very significant disabilities. No one should be ineligible for the service because of their disability or the challenges they may present to service providers.
Information Source: Clinical records, interview
Item Scoring: [Yes (5) or No (1)]

1.) There are treatment exclusion criteria in effect for an individual with an assessed need.
2.) N/A
3.) N/A
4.) N/A
5.) There are not any treatment exclusion criteria in effect for an individual with an assessed need.

Element #26 - Rapid Job Search for Competitive Job is Used
Definition: Individuals are assisted in finding jobs by making contacts with employers. An individual's first contact with an employer about a competitive job is within 3 months of authorization of employment services.
Rationale: Jobs are not secured by training to look for jobs, but are secured instead by actually looking for jobs. Supported employment should not involve long term training or preparation prior to job search.
Information Source: Clinical records
Item Scoring: [Yes (5) or No (1)]

1.) An individual's first contact with an employer about a competitive job is not within 3 months of the authorization of employment services.
2.) N/A
3.) N/A
4.) N/A
5.) An individual's first contact with an employer about a competitive job is within 3 months of the authorization of employment services.

Element #27 – Individualized Job Search
Definition: Employer contacts by the employment specialist are based on individual's job preferences, needs and abilities, rather than the available job market.
Rationale: To ensure employer contacts based on individual preference, skills, needs, and abilities.
Information Source: Clinical records, encounter data
Item Scoring: [Yes (5) or No (1)]

1.) Job contacts are not based on individual's preferences, needs and abilities.
2.) N/A

3.) N/A
4.) N/A
5.) Job contacts are based on individual's preferences, needs and abilities.

Element #28 – Vocational Interventions
Definition: Vocational interventions include a range of activities that assist individuals in choosing, getting and keeping employment. The interventions include career goal development, job and social life management training, support on and off the job site, job development and employer relations, coping skills, and work-related crisis interventions.
Rationale: To measure the extent to which the full array of vocational activities have been provided for individuals in supported employment or clinical documentation must indicate why individual did not receive services.
Information Source: Clinical records, encounter data
Item Scoring: [Yes (5) or No (1)]
1.) A full array of vocational activities was not provided to the individual.
2.) N/A
3.) N/A
4.) N/A
5.) A full array of vocational activities was provided to the individual.

Element #29 – Self-Sufficiency Plans
Definition: The Rural ACT team has mechanisms in place to insure that temporary rental assistance recipients make applications for Section 8, public housing or has a plan to increase personal income making housing affordable without assistance.
Rationale: This element measures the adequacy of the Plan for Self-Sufficiency for those people with temporary rental assistance or other financial subsidies. The reviewer must see clear documentation of provider activities to develop a Plan for Self-Sufficiency. When the Public Housing Authority is not accepting applications, a self-sufficient plan is still needed.
Item Scoring:
1.) A Plan for Self-Sufficiency addressing housing is not evident for the individual with an assessed need.
2.) N/A
3.) N/A
4.) N/A
5.) A Plan for Self-Sufficiency addressing housing is evident for the individual with an assessed need.

F. Criminal Justice

The Rural ACT team addresses the needs of individuals with criminal justice involvement, and ensures the provision of services that support mental health recovery and address problems that could lead to negative legal involvement, including re-arrest. It is important to understand the circumstances that led up to an arrest and incorporate this understanding into the individualized treatment plan. Because of the stigma attached to criminal history and mental illness, there will be special challenges in obtaining and maintaining housing, employment and benefits. Successful community integration is driven by the successful implementation of an integrated treatment plan combining a variety of interventions to address the individual's clinical and legal circumstances. The Rural ACT team will coordinate with law enforcement entities such as probation, parole, and the courts as necessary.

Element # 30 – Linkage with Law Enforcement
Definition: The Rural ACT team addresses the needs of individuals with criminal justice involvement, ensures the provision of services that support mental health recovery and address problems that could lead to negative legal involvement, including re-arrest. For each individual who is assessed with criminal justice needs, the ACT team helps the individual overcome the stigma attached to arrest and/or incarceration, addresses their special clinical and legal needs,

and promotes appropriate coordination with criminal justice agencies. The Rural ACT team will ensure linkage with law enforcement entities such as probation, parole, and the courts as necessary.
Rationale: This element supports the coordination of mental health and legal interventions and enhances the development of the individual's personal accountability in addressing their mental health needs and legal responsibilities.
Information Source: Clinical records, encounter data
Item Scoring: [Yes (5) or No (1)]

1.) There is not any documented evidence of coordinated interventions and collaboration among the individual (with an assessed need), the Rural ACT team and applicable law enforcement entities.
2.) N/A
3.) N/A
4.) N/A
5.) There is documented evidence of coordinated interventions and collaboration among the individual (with an assessed need), the Rural ACT team and applicable law enforcement entities.

G. Co-Occurring Psychiatric and Substance Abuse Disorders (COPSD) Services

The Rural ACT team addresses both psychiatric and substance abuse disorder needs and ensure the effective and coordinated provision of services to individuals with COPSD.

Element #31 – Integrated Treatment Plan

Definition: For each individual assessed and diagnosed with COPSD, there is an individualized integrated treatment plan (e.g., both mental illness and substance use disorders are addressed).
Rationale: This item requires that both disorders be addressed simultaneously in treatment.
Information Sources: Interviews with the program staff and clinicians, clinical records.
Item Scoring: [Yes (5) or No (1)]

1.) There is not an integrated treatment plan for the individual assessed and diagnosed with COPSD.
2.) N/A
3.) N/A
4.) N/A
5.) There is an integrated treatment plan for the individual assessed and diagnosed with COPSD.

Element #32 – Stage-Wise Interventions

Definition: COPSD treatment is consistent with the individual's stage of change (Prochaska, J. & DiClemente, C., 1992: precontemplation, contemplation, preparation, action, maintenance, relapse). The Stages of Change model shows that, for most persons, a change in behavior occurs gradually, with the patient moving from being uninterested, unaware or unwilling to make a change (pre-contemplation), to considering a change (contemplation), to deciding and preparing to make a change. Genuine, determined action is then taken and, over time, attempts to maintain the new behavior occur. Relapses are almost inevitable and become part of the process of working toward life-long change. The stages of change are:

- Pre-contemplation (Not yet acknowledging that there is a problem behavior that needs to be changed). Education and treatment models: Locus of Control, Health Belief Model, and Motivational Interviewing.
- Contemplation (Acknowledging that there is a problem but not yet ready or sure of wanting to make a change). Education/ treatment models: Health Belief Model, and Motivational Interviewing.
- Preparation/Determination (Getting ready to change) Education/treatment model: Problem solving, cause and effect relationships, the recovery process
- Action/Willpower (Changing behavior) Education/treatment model: Psychosocial Rehabilitative Services, 12-Step Program
- Maintenance (Maintaining the behavior change) Education/treatment model: 12-Step Program
- Relapse (Returning to older behaviors and abandoning the new changes) Education/treatment model: 12-Step Program, Motivational Interviewing.

Rationale: This item requires person-centered treatment whereby services match the individual's level of readiness to participate and benefit from services.
Information Sources: Interviews with clinical supervisor, clinicians, individuals, clinical records
Item Scoring: [Yes (5) or No (1)]

1.) Treatment does not reflect the individual's stage of change.
2.) N/A
3.) N/A
4.) N/A
5.) Treatment reflects the individual's stage of change.

Element #33 - Self-help Liaison
Definition: Clinicians show attempts to engage individuals assessed and diagnosed with COPSD in community-based substance appropriate self-help programs, such as Alcoholics Anonymous, Narcotics Anonymous, Double Trouble or Dual Recovery.
Rationale: This item supports the development of the individual's community support network.
Information Sources: Interviews with the program director/coordinator, clinicians and individuals, clinical records
Item Scoring: [Yes (5) or No (1)]

1.) Evidence indicates attempts were not made to engage the individual in self-help programs.
2.) N/A
3.) N/A
4.) N/A
5.) Evidence indicates attempts were made to engage the individual in self-help programs.

Element #34 - Secondary Intervention for Treatment Non-Responders
Definition: Individuals who are not responding to COPSD treatment are identified, evaluated and offered appropriate secondary interventions. Secondary interventions might include arranging supervised housing, intensive family interventions, and residential treatment.
Rationale: This item requires an ongoing monitoring of treatment and a change to more beneficial treatment options.
Information Sources: Interviews with the team leader, clinicians and individuals, clinical records
Item Scoring: [Yes (5) or No (1)]

1.) The treatment non-responder was not identified, evaluated, and offered alternative interventions.
2.) N/A
3.) N/A
4.) N/A
5.) The treatment non-responder was identified, evaluated, and linked to alternative interventions.

H. Family Support and Education

With active involvement of the individual, Rural ACT staff work to include the individual's community support systems (e.g., family, significant others, landlords, employers) as a part of Rural ACT services. Individuals and their support network are taught about mental illness and the skills needed to better manage their illnesses and their lives. It is often necessary to help improve family relationships in order to reduce conflicts and increase individual autonomy. These services may include:

- individualized education about the individual's illness and the support system's role in the therapeutic process,
- intervention skills to assist the individual in ongoing communication and collaboration between Rural ACT team and the support network,
- referrals to support programs and advocacy organizations, and
- assistance to individuals with children (e.g., parenting training, counseling, and assistance in restoring relationship with children not in the individual's custody).

Element #35 – Work with Support System

Definition: The Rural ACT team provides frequent support and education for the support network (e.g., family, significant others, church, AA, local clubs, support groups, school groups, landlords, employers) of each individual.

Rationale: To determine if the individual's support network received education and support in accordance with the individual's desires and needs identified in the treatment plan.

Information Sources: Clinical records, individual/family interviews, treatment plans, encounter data

Item Scoring: [Yes (5) or No (1)]

1.) Documentation does not indicate the support network was engaged in treatment or documentation does not indicate the individual's preference for support network involvement.
2.) N/A
3.) N/A
4.) N/A
5.) There is documentation that the Rural ACT team has made attempts to engage the individual's support network or that the individual refused.

Reference:

Program for Assertive Community Treatment - http://www.nami.org/Template.cfm?Section=ACT-TA_Center

Criminal Justice/Mental Health Consensus Project, coordinated by the Council of State Governments – http://consensusproject.org/mhcp/Navigating-MHC-Maze.pdf

http://gainscenter.samhsa.gov/html/resources/publications.asp